

New Prescription Order Form



Total Number of Prescriptions:

Mail this form to: PrimeMail® PO Box 660319 Dallas, TX 75266-0319 For added service: Visit www.floridablue.com or call 888.849.7865 TTY 711

Llame la farmacia de PrimeMail en 888.849.7865 o el registro sobre nuestro sitio del web en www.floridablue.com

CARD HOLDER INFORMATION				
Card Holder's ID	yy)			
Card Holder's Last Name	Card Holde	r's First Name MI		
Patient's Last Name (if different than c	ard holder's last name) Patient's First Name	MI		
Patient's Gender: () Male () Female	Patient's Date of Birth (mm/dd/yyyy) Patient	's Phone Number		
Patient's Permanent Address				
City	State Zip Code			
Patient's E-mail Address	Cont	tact by: () E-mail () Phone		
DRUG ALLERGIES	HEALTH CONDITIONS			
O None O Codeine O Sulfa	Arthritis () Diabetes () Glaucoma	a () High cholesterol		
○ Aspirin ○ Erythromycin ○ Penicillin ○ Asthma ○ Depression ○ Heart condition ○ Hypertension				
Other	Other			
PATIENT'S NEW PRESCRIPTIONS				
Drug Name Phy	sician/Prescriber's Name & Phone Number	Do not fill at this time		
		0		
		0		
		0		

Mail the original physician-signed prescriptions with this completed form. For multiple dependents please use multiple forms. If more than 3 prescriptions are needed, write the requested information from this table on a separate piece of paper and enclose with your order. Additional processing time may be required for prescriptions that require physician clarification. For prescriptions to be filled at a later date, call the customer service number above to activate.

CONTINUED ON BACK

SHIPPING INFORMATION				
Regular: No charge Seco	nd business day: \$15*	O Next bus	siness day: \$22*	*Additional costs charged to you.
Shipping time does not include pr	ocessing time. Shippi	ng prices are su	bject to change.	
We are unable to ship second busine	ess day or next business	s day orders to P	O boxes.	
Shipping address must be a physical	l location.			
Alternate Shipping Address (if different	ent than permanent addr	ess)		
City	State Zip C	ode	Phone Number	
① This is a change of address	○ This is a one time add	dress () Sea	sonal address from	to
PAYMENT INFORMATION				
Payment is due with each order and r may delay processing. There is a \$2			ney order. Orders red	eived without payment
Check or money order Please make check or money order include your member ID on the mem			() Check) Money Order
Credit card information To authorize payment by credit card, MasterCard, VISA and American Expotherwise.				
Credit Card Number	Expir	ation Date		
O Use credit card on file, with the last	st 4 digits of:			
Signature		Dat	te	
Pharmacy law may permit pharmacis	sts to substitute a less e	xpensive FDA-ap	proved generically	equivalent medication

Pharmacy law may permit pharmacists to substitute a less expensive FDA-approved generically equivalent medication for a brand-name medication unless you or your prescriber indicate otherwise. Some health plans require the patient to pay the difference between generic and brand name cost.

By returning this form to PrimeMail, you consent to the release and use of the patient's health information to the patient's health plans and health care providers/agents for health benefits management. Prime Therapeutics' use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

PrimeMail may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically appropriate product.

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